26. Personal care services. (continued)

m) services not specified as covered under medical assistance as personal care services;

n) effective January 1, 1996, assessments by personal care provider organizations or by independently enrolled registered nurses;

o) effective July 1, 1996, services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided (applies to foster care settings);

p) effective January 1, 1996, personal care services that are not in the service plan;

q) home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

r) services to other members of the recipient's household;

s) any home care service included in the daily rate of the community-based residential facility where the recipient resides;

t) personal care services that are not ordered by the physician; or

u) services not authorized by the commissioner or the commissioner's designee.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to this Attachment.

- Not provided.

SUPPLEMENTARY NOTES

The following services are not covered under the Medical Assistance program:

1. a health service paid for directly by any other source, including third-party payers and recipients, unless the recipient's eligibility is retroactive and the provider bills the Medical Assistance program for the purpose of repaying the recipient;

2. drugs which are not in the Drug Formulary or which have not received prior authorization;

3. a health service for which the required prior authorization was not obtained;

4. autopsies;

5. missed or canceled appointments;

6. telephone calls or other communications that were not face-to-face between the provider and the recipient;

7. reports required solely for insurance or legal purposes unless requested by the local agency or the Department;

8. an average procedure including cash penalties from recipients, unless provided according to state rules;

9. a health service that does not comply with Minnesota Rules, parts 9505.0170 to 9505.0475

10. separate charges for the preparation of bills;

11. separate charges for mileage for purposes other than medical transportation of a recipient;

12. a health service that is not provided directly to the recipient, unless the service is a covered service;

SUPPLEMENTARY NOTES (continued)

13. concurrent care by more than one provider of the same type of provider or health service specialty, for the same diagnosis, without an appropriate medical referral detailing the medical necessity of the concurrent care, if the provider has reason to know concurrent care is being provided. In this event, the Department shall pay the first submitted claim;

14. a health service, other than an emergency health service, provided to a recipient without the knowledge and consent of the recipient or the recipient's legal guardian, or a health service provided without a physician's order when the order is required by state rules, or a health service that is not in the recipient's plan of care;

15. a health service that is not documented in the recipient's health care record or medical record as required by state rules;

16. a health service other than an emergency health service provided to a recipient in a long-term care facility and which is not in the recipient's plan of care or which has not been ordered, in writing, by a physician when an order is required;

17. an abortion that does not comply with 42 CFR §§441.200 to 441.208 or Minnesota Statutes, §256B.0625, subdivision 16;

18. a health service that is of a lower standard of quality than the prevailing community standard of the provider's professional peers. In this event, the provider of service of a lower standard of quality is responsible for bearing the cost of the service;

19. a health service that is only for a vocational purpose or an educational purpose that is not related to a health service;

SUPPLEMENTARY NOTES (continued)

20. except for an emergency, more than one consultation by a provider per recipient per day; for purposes of this item, "consultation" means a meeting of two or more physicians to evaluate the nature and progress of disease in a recipient and to establish the diagnosis, prognosis, and therapy;

21. except for an emergency, or as allowed in item 22, more than one office, hospital, long-term care facility, or home visit by the same provider per recipient per day;

22. more than one home visit for a particular type of home health service by a home health agency per recipient per day, except as specified in the recipient's plan of care;

23. record keeping, charting, or documenting a health service related to providing a covered service;

24. services for detoxification which are not medically necessary to treat an emergency;

25. artificial insemination;

26. reversal of voluntary sterilization;

27. surgery primarily for cosmetic purposes; ~~and~~

28. ear piercing; and

29. gender reassignment surgery and other gender reassignment medical procedures, including drug therapy for gender reassignment (unless the recipient began receiving such services before July 1, 1998).